Claims Clues

A Publication of the AHCCCS Claims Department January, 2000

Lab Claims for Dialysis Patients Face Review

Effective with claims for dates of service on and after Feb. 1, 2000, AHCCCS will conduct a prepayment review of all fee-for-service claims for laboratory services performed for dialysis patients.

The following documentation justifying medical necessity must be submitted with each claim:

- Results of the laboratory tests
- Physician's orders for each test
- Medical documentation demonstrating that the test is medically necessary

Services for which all the required documentation is not provided will be denied. Providers who submit documentation after the claim has been submitted to AHCCCS must write the AHCCCS Claim Reference Number (CRN) on the documentation. The documentation will be imaged and linked to the claim.

Dialysis facilities are reimbursed a composite rate that includes certain laboratory services. The dialysis facility is responsible for the reimbursement of these laboratory services.

Services included in the composite rate may not be billed separately to AHCCCS unless they are ordered by a physician, medically necessary, and provided more frequently than specified by policy. Other separately billable laboratory services may be covered by AHCCCS if they are ordered by a physician and medically justified by documentation.

AHCCCS follows Medicare policy for billing and reimbursement of laboratory services for dialysis patients. ❒

Agency Planning Next Provider Meetings

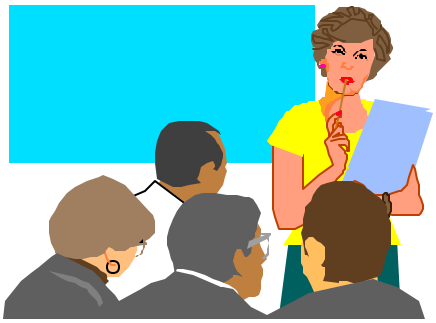
The next quarterly Provider Information Meetings are tentatively scheduled for late February or early March.

The meetings, which will be held in Phoenix, Tucson, and Flagstaff, are designed to provide a forum where AHCCCS can disseminate information to providers and or providers' staff and also to allow providers and or their staff to discuss issues with AHCCCS staff.

The information meetings will be held from 9:00 a.m. until noon.

Tentative discussion topics for the meetings include:

- Interactive Voice Response (IVR) verification system
- Medicare crossover, including QMB Only



- Importance of provider locator codes
- Electronic Remittance Advice update
- Provider credentialing status report
- Using the on-line *AHCCCS Medical Policy Manual*
- KidsCare issues
- Universal recipient application form

The meeting will include a question and answer session.

In the afternoon, AHCCCS staff will conduct an "Introduction to Billing AHCCCS" training session for HCFA 1500 billers. The training is intended for new AHCCCS billers and will include a hands-on session on completing the HCFA 1500 claim form.

The afternoon training sessions are scheduled for 1:30 – 4:30 p.m.

Providers and/or their staff members who are interested in attending one of the meetings should complete the attached interest form and submit it to AHCCCS no later than Feb. 4, 2000. The form includes a section where providers may suggest discussion topics. ❒

QMB Only Update .....Page 2

QMB Update

Payment Cycle Runs; Timeliness Rules Outlined

The first payment cycle for QMB Only claims submitted to the AHCCCS Administration was run on January 14, and the status of these claims is reported to providers in their AHCCCS remittance advices.

AHCCCS began processing fee-for-service QMB Only claims on October 1. Prior to October 1, providers were required to send QMB only claims to the TPA.

AHCCCS has received a report on the status of QMB Only claims submitted to the TPA prior to October 1. The data will be used to avoid duplicate payment of claims.

Providers with questions about the *status* of QMB Only claims should call the Claims Customer Service Unit at (602) 417-7670 (Option 4).

Providers with questions about *submission* of QMB Only claims should call (602) 417-7940.

The following policies apply solely to QMB Only claims:

- Timeliness requirements
  - QMB Only claims will be considered timely if initially received by AHCCCS within six months from the date of Medicare payment.
  - If the initial claim is received within 6 months, the provider may resubmit the claim up to 12 months from the date of Medicare payment.
  - The claim must achieve clean claim status within 12 months.
- UB-92 discounts/penalties
  - AHCCCS will not take a quick pay discount nor pay a slow pay penalty on UB-92 QMB Only claims.

Here are some guidelines for providers to follow:

QMB Only Claims

Until further notice, providers should send QMB only fee-for-service claims to:

AHCCCS Administration
Attn: Lori Petre
P.O. Box 25520
Phoenix, AZ 85002

Providers should write "QMB Only" on the envelope and include the Medicare EOMB with the claim.

The Medicare coinsurance and deductible, if applicable, must be entered in Field 24K of the HCFA 1500 claim form. Enter coinsurance first and the deductible as the second figure.

When submitting a HCFA 1500 claim for a Medicare HMO member, the charges in Field 24F must be the provider's billed charges, not the co-pay amount. The co-pay must be entered in Field 24K as coinsurance with a zero entered as the deductible.

Coinsurance and deductible must be entered in Field 41 of the UB-92 claim form using value code A1 to indicate Part A deductible and A2 for Part A coinsurance, if applicable.

Providers must enter their AHCCCS provider ID and 2-digit locator code in the "PIN#" section of Field 33 of the HCFA 1500. A facility's AHCCCS provider ID number must be entered in Field 51 of the UB-92.

Medicare Crossover

AHCCCS also is initiating an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/ BlueShield of North Dakota, BlueCross/BlueShield of Arizona, and BlueCross/Blue-Shield of Texas (Trailblazers). This process should be in place by March 1. AHCCCS will notify the providers of the change.

When a provider submits a claim to Medicare for an AHCCCS recipient, the claim will be automatically crossed over to AHCCCS when Medicare issues payment. Providers no longer will need to submit claims to AHCCCS for paid Medicare claims for AHCCCS recipients.

Denied and adjusted Medicare claims will not be automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS and must comply with the requirements described previously.

All Medicare crossover claims will be identified on the provider's remittance advice. ❐

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 57 (Residential treatment facility)

- Add Z3125 - Z3127 effective 10/01/1999

Provider type 47 (Registered dietician)

- Add W2600 and W2601 effective 10/01/1999 ❐

Oxygen Equipment Reimbursement Revised

AHCCCS' policy on oxygen equipment conforms to Medicare's policy on reimbursement of these codes, and providers must bill for services correctly in order to receive proper reimbursement.

According to Medicare, certain oxygen rental rates represent a monthly allowance per beneficiary. Any claim for these oxygen services should be billed with one unit for a calendar month.

Reimbursement of the single unit represents the entire month's rental regardless of the actual number of days that services are provided.

Last year, the AHCCCS capped fees for the oxygen equipment codes listed below were changed to a monthly rental rate.

The AHCCCS Administration Claims Department has been special handling claims for oxygen equipment to ensure that providers are paid correctly. Effective April 1, 2000, this special handling process will be discontinued, and these claims will be processed in accordance with the standard procedure for all fee-for-service claims.

Providers must ensure that they bill for services correctly in order to receive proper reimbursement.

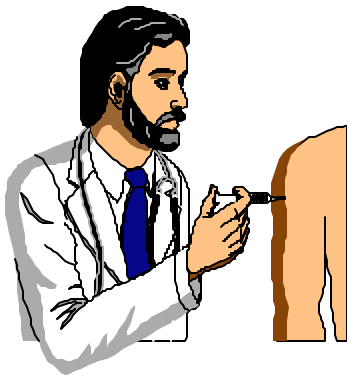
One procedure code; E0935, is a *daily* rate, and the rate has been recalculated. The new rental rate reimbursement of this code is $18.43 per day. When billing this code, one unit equals one day. ❒

Code	Monthly Rental Rate	Code	Monthly Rental Rate	Code	Monthly Rental Rate
E0424	$194.40	E1400	$194.40	E1404	$194.40
E0431	$36.00	E1401	$194.40	E1405	$222.90
E0434	$36.00	E1402	$194.40	E1406	$211.80
E0439	$194.40	E1403	$194.40		

Providers May Not bill for Vaccine Administration under VFC

Providers must not use the immunization administration CPT codes 90471 and 90472 when billing for vaccines under the federal Vaccines for Children (VFC) program.

Under the VFC program, providers are reimbursed a capped fee for administration of vaccines to Medicaid-eligible (Title XIX) recipients 18 and younger.



Providers must bill the CPT code for the immunization with the AHCCCS-specific "VA" modifier that identifies the immunization as part of the VFC program. Because the vaccine is made available to providers, they must bill only for administration of the vaccine and not for the vaccine itself. ❒

Only Oral Surgeons May Bill E/M Codes

Only oral surgeons registered as Provider Type 07 - Dentist may use CPT Evaluation and Management (E/M) codes to bill the AHCCCS Administration for office visits.

Dentists who are not oral surgeons must use HCPCS codes ("D" codes) to bill for office visits and evaluation services.

The codes are:

- D0120 - Periodic oral exam
- D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed
- D9440 - Office visit -- after regularly scheduled hours
- D0140 - Limited oral evaluation -- problem focused
- D0150 - Comprehensive oral evaluation
- D0160 - Detailed and extensive oral exam -- problem focused

A "Coding Corner" article in the October, 1999, issue of *Claims Clues* incorrectly indicated that all dentists could bill office visits to the AHCCCS Administration using E/M codes. ❒

Modifier 59 Not Appropriate for All Services

Modifier 59 indicating "Distinct Procedural Service" generally should be used only when billing the AHCCCS Administration for professional services.

The *CPT Manual* describes Modifier 59 as follows:

"Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician."

To determine if a particular modifier can be billed with a specific code, providers should call the Claims Customer Service Unit at (602) 417-7670 (Option 4). ❒

Providers Asked to Follow Claim Submission Guidelines

To enable the AHCCCS Claims Control Unit to process claims as efficiently as possible, providers are asked to follow these guidelines when submitting paper claims to the AHCCCS Administration:

- Providers should "burst" HCFA 1500 claim forms when the forms are printed on continuous feed paper. They should not be submitted with pages joined at the perforations.
- If one page of an EOMB applies to claims for multiple recipients, providers must submit a separate copy of the EOMB with each claim. AHCCCS images the copy of the EOMB along with the claim.
- Providers must not submit multiple-page claims that have been copied on both sides of the paper. Each page must be on a separate piece of paper and numbered (e.g., 1 of 3, 2 of 3, 3 of 3). Pages should be paper clipped together in the upper left-hand corner. Providers should not staple the pages.

All claims (except QMB Only claims) and documentation should be mailed to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

QMB Only claims should be mailed to:

AHCCCS Administration
Attn: Lori Petre
P.O. Box 25520
Phoenix, AZ 85002

Providers should write "QMB Only Claims" on the envelope. ❒

Telephone Transfer Problems Studied

AHCCCS staff members are investigating why providers who use the Interactive Voice Response (IVR) verification system occasionally are placed on hold for long periods of time when attempting to transfer to another area.

The IVR system allows providers to verify eligibility and enrollment by entering information on a touch-tone telephone and following recorded instructions. After obtaining the information from IVR, providers may transfer to another AHCCCS Units, such as the Verification Center, Provider Registration, or Claims Customer Service.

However, occasionally providers are placed on hold for long periods of time rather than being transferred.

If this happens, providers should hang up and call the unit directly to obtain any additional information or to ask questions. The provider also should report that the call was not transferred from IVR. ❒

Quarterly Provider Meetings

The AHCCCS Administration will conduct its next quarterly provider meetings in late February or early March. The meetings, which will be held in Phoenix, Tucson, and Flagstaff, are designed to provide a forum whereby AHCCCS can disseminate information to providers and also to allow providers to discuss issues with AHCCCS staff. It is anticipated that these meetings will last 2 to 2½ hours. The tentative agenda for the first meeting includes the following topics:

- ✓ Interactive Voice Response (IVR) verification system
- ✓ Medicare crossover, including QMB Only
- ✓ Importance of provider locator codes
- ✓ ,Electronic Remittance Advice
- ✓
- ✓ Provider credentialing
- ✓ The on-line AHCCCS Medical Policy Manual
- ✓ KidsCare issues
- ✓ Universal recipient application form
- ✓ Question-and-answer session

In the afternoon, AHCCCS staff will conduct an "Introduction to Billing AHCCCS" training session for HCFA 1500 billers. The training is intended for new AHCCCS billers and will include a hands-on session on completing the HCFA 1500 claim form. The afternoon training sessions are scheduled for 1:30 – 4:30 p.m.

If you are interested in attending one of these meeting, please complete the form below and fax it to the AHCCCS Claims Policy/Training Unit at (602) 256-1474. You also may mail this form to:

AHCCCS Claims Policy/Training Unit
701 E. Jefferson Street, MD 8100
Phoenix, AZ 85034

Please return this form no later than Feb. 4, 2000. Thank you.

Provider Name: _____ AHCCCS Provider ID: _____

Provider Type:
(e.g., physician, hospital, emergency transportation, etc.) _____ Specialty: (Physicians only) _____

Street Address or P.O. Box: _____

City: _____ State: _____ ZIP: _____

Contact Person: _____ Telephone: ( ) _____

FAX: ( ) _____

Suggested topics: _____

_____

_____

I would prefer to attend a focus group in (Please select one): How many will attend? _____

Phoenix ☐ Tucson ☐ Flagstaff ☐

I (We) will ☐ will not ☐ attend the training session If attending training, how many? _____